

Corona Advanced Imaging 175 E. 9th Street Corona, CA 92879-3144

Phone: (951) 340-0312 Fax: (951) 582-9805

	PATIENT INFORMA	TION FORM										
Last Name:	First Name:		Middle Name:									
MRN:	DOB:		Gender:									
Address 1:												
Address 2:												
	ate:		Zip Code:									
Home Phone: Work Phone:	Cell Ph		Email:									
Preferred Contact Method: ☐ Home Phone	☐ Cell Phone ☐ Work P	hone Email	□ Mail									
Preferred Delivery Method: ☐ Mail ☐ Electronic	Preferred Lang	uage:										
Race: ☐ American Indian / Alaska Native ☐ Asian	☐ Black or African American	☐ Native Hawaiian / Oth	er Pacific Islander	☐ White / Caucasian								
Are you: ☐ Hispanic ☐ Not Hispanic Referring Physician:												
RESPONSIBLE PARTY INFORMATION												
Last Name:	First Name:											
Patient's Relationship to Responsible Party:			Phone:									
Address 1:												
Address 2:												
City: Sta	ite:		Zip Code:									
	Primary Insurance I	nformation										
For Medicare Patients: Are You or Your Spouse W	orking?: □ YES □	NO If Y	es, whom?									
Primary Insurance Name:		Pla	ın Name:									
Address:												
City:	State:	Zip	:									
Policy #:	Group #:	DO)B:									
Policy Holder Name:		Sex	X:									
Policy Holder Address:												
City:	State:	Zip	:									
Patient's Relationship to Policy Holder:												
	Secondary Insurance											
For Medicare Patients: Are You or Your Spouse W	/orking?: □ YES □		'es, whom?									
Primary Insurance Name:		Pla	ın Name:									
Address:												
City:	State:	Zip										
Policy #:	Group #:	DO										
Policy Holder Name:		Sex	X:									
Policy Holder Address:	01-1											
City:	State:	Zip	-									
Patient's Relationship to Policy Holder:												
	MEDICAL INFOR	MATION										
Is this visit related to an auto accident?				☐ Yes	□ No							
Is this visit related to an injury sustained while at work	?			□ Yes	□ No							

Patient: DOB: Date of Service: MRN:

Date of Injury:				Height:	ft	in. Wo	eight:				
SMOKING STATUS:											
☐ Current Every Day ☐	Current Some	Days □ Nev	er smoked	☐ Smoker, current status unknow	vn □ Form	er smoker [□ Unknown				
ACTIVE MEDICATIONS: ☐ None											
☐ ActoPlus Med	toPlus Med			☐ Glyburid Met	□М	☐ Metaglip					
☐ Avandamet	☐ Glucophage			☐ Glycomet	□М	☐ Metformin					
□ Diabex	□G	Blucovance		□ Janumet	□ Pi	□ PrandiMet					
☐ Diafomin	□G	Blumetza		☐ Kombiglzexr	□Ri	☐ Riomet (liquid form of Metformin)					
MEDICAL HISTORY: □ None											
☐ Aneurysm Clip / Coil ☐ Breast Implants			☐ Insulin Pump	□ Pa	□ Parplegic						
☐ Aneurysm Had Surgery	y □ Cancer			☐ Metal In the Body	□ Pi	☐ Previous CT Contrast Reaction					
☐ Aneurysm NO Surgery	☐ Diabetes		☐ Morphine Pump	□ Pi	☐ Previous MR Contrast Reaction						
☐ Asthma	□н	☐ Hypertension		☐ Pacemaker	□R	☐ Renal Disease					
ALLERGIES: ☐ None	•			·							
☐ Adhesive Tape	☐ Mild	☐ Moderate	☐ Severe	□ Latex	☐ Mild	☐ Moderate	☐ Severe				
☐ Bee Sting	☐ Mild	☐ Moderate	☐ Severe	☐ Lidocaine / Novacaine	☐ Mild	□ Moderate	☐ Severe				
☐ Betadine (Topical Iodine)	□ Mild	☐ Moderate	☐ Severe	☐ Mold	☐ Mild	☐ Moderate	☐ Severe				
☐ Contrast (Med. Imaging)	☐ Mild	☐ Moderate	☐ Severe	☐ Peanut or other nut	☐ Mild	□ Moderate	☐ Severe				
□ Dog, Cat, or Animal	☐ Mild	☐ Moderate	☐ Severe	☐ Penicillin	☐ Mild	□ Moderate	☐ Severe				
☐ Dust	☐ Mild	☐ Moderate	☐ Severe	☐ Rubbing Alcohol	☐ Mild	□ Moderate	☐ Severe				
□ Fruit	☐ Mild	☐ Moderate	☐ Severe	☐ Shellfish	☐ Mild	☐ Moderate	☐ Severe				
☐ Grass / Pollen	☐ Mild	☐ Moderate	☐ Severe	☐ Sulfa Drug	☐ Mild	☐ Moderate	☐ Severe				
Mild allergic reactions include hives, itching, nasal congestion, rash and watery eyes. Moderate allergic reactions include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomitting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconciousness. Severe allergic reaction is anaphalytic shock.											
TO OUR FEMALE PATIENTS											
Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.											
Signature				Date							
Date of Last Menstrual Peri	od:/										
AUTHORIZATION & AGREEMENT											
I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.											
Signature of Patient, or Persona	al Representative			Date							

Patient: DOB: MRN: Date of Service: